Detailed Medical History and Testing Summary

Supporting information for HHS RF/EMF Request for Information

Docket: HHS-OASH-2026-0397 **Period covered:** approximately 2013-2026

Patient: Hideko Go

1. Beginning of Symptoms - 2013

My recurrent unexplained symptoms began around 2013. One of the earliest significant problems was sudden severe vertigo accompanied by vomiting and collapse. Over time, I also began experiencing intermittent stabbing, sharp, or electrical-like pains in different areas of my body. During the first several years, these pains occurred particularly in my legs; later the location became more widespread and variable.

Symptoms over the years have included sudden stabbing or electrical-like pains; severe head pain; deep chest and rib pain; eye and facial pain; foot, ankle and leg pain; vertigo including episodes with vomiting; tinnitus and unusual ear sensations; skin stinging and redness; temporary visible lines and other skin changes; and other transient sensory symptoms.

2. Neurological Imaging and Evaluation

November 2013: Brain MRI/MRA was performed and did not provide an explanation for the continuing pattern of symptoms.

February 2015: Another brain MRI was performed, without a finding explaining the complete symptom pattern.

October 2016: Cervical-spine MRI did not provide a unifying explanation for the recurrent migratory symptoms.

March 2023: Another brain MRI was performed. Neurological imaging over the years has not established a structural neurological explanation for the overall syndrome.

3. Vertigo, Ear Symptoms and Vestibular Evaluation

Vertigo has been part of my history since approximately 2013. Some episodes have been severe and included vomiting. I have also experienced tinnitus and unusual ear sensations.

October 2022: Formal vestibular evaluation was described as essentially normal and did not provide a complete explanation for the recurring symptoms.

4. Severe Chest and Rib Pain

Examples include chest pain in April 2022 lasting approximately 30 minutes; episodes in July 2022 involving chest, mouth and lower-head pain lasting approximately one hour or longer; severe deep right rib/chest pain in March 2023 persisting approximately three days; recurrent severe deep chest/rib pain in March 2024; and another chest-pain episode in May 2025.

Because chest pain can represent serious cardiovascular disease, I underwent cardiac evaluation, including cardiac monitoring and a **cardiac MRI in November 2025**. These evaluations did not identify a cardiac condition explaining the overall recurring symptom pattern.

5. Eye and Visual Symptoms

I have experienced deep eye pain, tearing, blurred vision, and other unusual visual phenomena. I received urgent eye evaluation in **May 2025** and later neuro-ophthalmologic evaluation in **December 2025**.

I have also described visual phenomena occurring with my eyes closed, including dots or shapes and bright blue or white light, particularly while falling asleep. Ophthalmologic and neuro-ophthalmologic evaluation has not identified an explanation for the complete systemic symptom pattern.

6. Skin Findings and Dermatology

Some episodes have involved visible skin changes, including red areas, red lines, stinging sensations, and temporary indentations or other changes in appearance. I have photographed some of these changes.

December 2025: A skin biopsy did not show mucinosis or scleromyxedema. Findings included mild papillary fibrosis, solar elastosis, trace chronic inflammation, and possible subtle edema. The biopsy did not establish a dermatological condition explaining the complete recurrent symptom pattern.

7. Neuromuscular Testing

December 2025: Nerve-conduction studies and EMG testing were normal. No evidence of a neuromuscular disease explaining the symptoms was identified.

8. Neurology Evaluation - January 2026

A neurological evaluation addressed recurrent stabbing and electrical-like pains occurring for seconds to minutes in different parts of my body. The neurologist reviewed prior brain imaging, cervical-spine imaging, laboratory testing, and the normal EMG/NCS. The neurological examination was reassuring.

Small-fiber neuropathy was considered, although the examination did not establish it. The diagnosis recorded was **paresthesia of skin**. No neurological disease was identified that explained the complete symptom history.

9. Psychiatric Evaluation - 2026

Because previous clinicians had raised the possibility of a psychological or somatic explanation, I also underwent psychiatric evaluation. The assessment recorded **unspecified somatic symptom disorder, mild**. No psychiatric medication was prescribed, and outpatient therapy was recommended. Depression and anxiety screening scores were low.

I subsequently disputed factual background information contained in portions of that record and requested correction. I include this evaluation to provide a complete picture of the different explanations considered. A psychiatric assessment does not by itself establish the physical mechanism responsible for individual symptoms.

10. Additional Neurological Evaluation - August 2026

I obtained another neurological consultation because the unexplained symptoms continued. The neurologist documented the long history of intermittent, abrupt pain occurring in small areas of the body, sometimes lasting seconds or minutes. The neurological examination showed normal strength.

The diagnosis recorded was **migratory pain**. The neurologist did not find evidence supporting a neuromuscular disease. Additional neurological testing, including EEG and further evaluation, was discussed or ordered.

11. Foot and Extremity Symptoms - 2026

During 2026, I continued experiencing episodes involving both feet and ankles, including significant pain and swelling. Foot X-rays showed mild left hallux valgus and bilateral plantar calcaneal spurs. These findings do not explain the complete history of sudden migratory pain involving many different areas of my body.

12. Environmental Observation

Throughout this history, I have repeatedly observed that some symptoms appear more frequently or become more severe in certain indoor environments. At other times, going outdoors or changing location has coincided with improvement. I have experienced symptoms at home, in hotels, vehicles, trains and other transportation settings, and other indoor locations.

These observations **do not establish that RF/EMF exposure caused my symptoms**. I did not have laboratory-grade RF/EMF monitoring synchronized with individual attacks, and changing environments changes numerous other variables. Determining whether RF/EMF, another environmental factor, an unrelated medical process, or a combination of factors is involved requires controlled research.

13. Overall Medical Findings

During approximately 13 years of symptoms, I have undergone multiple brain MRI examinations, brain MRA, cervical-spine MRI, neurological examinations, nerve-conduction studies and EMG, cardiac monitoring, cardiac MRI, ophthalmology and neuro-ophthalmology examinations, vestibular testing, dermatological examination and skin biopsy, laboratory testing, psychiatric evaluation, and additional specialist consultations.

Despite this extensive investigation, **no single established medical diagnosis has adequately explained the complete pattern of recurrent, migratory physical symptoms.** This history does not prove an RF/EMF cause. The absence of a unifying diagnosis is one reason I believe patients with similar unexplained symptoms should be eligible for carefully designed research.

14. Request to HHS

I respectfully ask HHS to consider developing a research pathway for individuals with long-standing unexplained symptoms such as mine. Ideally, research would combine objective medical evaluation with simultaneous environmental RF/EMF measurements. When scientifically appropriate, blinded exposure protocols could help determine whether symptoms or measurable physiological changes correlate with RF/EMF exposure.

I also ask HHS to examine relevant research concerning **Anomalous Health Incidents (AHI)** and determine whether any established findings, research methods, exposure-assessment techniques, or clinical approaches could be useful for evaluating civilian patients. I ask HHS to review proposed civilian AHI clinical approaches, including those advocated by **Dr. Len Ber**, together with broader peer-reviewed scientific evidence.

My request is not for HHS to presume the cause of my symptoms. My request is for objective investigation, appropriate civilian research, and evidence-based clinical guidance.